

Kentucky Diabetes Prevention and Control Program (KDPCP)



Cost Center 809 (Diabetes)

FY17 Guidance Document



Kentucky Public Health
Prevent. Promote. Protect.

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Purpose

Funds are available to support evidenced-based public health approaches to diabetes prevention and control in alignment with the Department for Public Health's diabetes-related federal grant, the 2015 Kentucky Diabetes Report <http://chfs.ky.gov/dph/info/dpqi/cd/diabetes.htm> and other state plan documents.

Use of Funds

Funds will be allocated in the 809 cost center. To accomplish greater outcomes for a single county/region, LHDs are encouraged to supplement these funds with additional local funds, collaborate with adjacent LHDs, or partner with other community organizations.

Appropriate use of these funds includes:

- Staff and operating expenses related to the program
- Training and meeting expenses (including travel) related to program needs (i.e., diabetes continuing education, certification/licensure, software training, participation in state diabetes coalition, etc.)
- Electronic data collection and tracking
- Relevant program supplies and materials
- Contracting with other agencies to provide targeted services (e.g. Diabetes Prevention Program/Diabetes Self-Management Education)

Provision of clinical services (labs, medication, etc.) are not allowable If these services appear in the budget, adequate local funds should appear on the revenue side of the budget to cover them.

Target Population

Adult Kentuckians with or at risk for diabetes or prediabetes are the population of focus. In addition, African American, Hispanic/Latino, senior and Appalachian populations have diabetes-related disparities and should be priority target audiences when applicable.

Targeted Outcomes

The following are the priority short term results and outcomes for this effort. Within the LHD service area:

- Increase the number of CDC Recognized Diabetes Prevention Programs (DPPs)
- Increase the number of DPP delivery sites and/or times program is available
- Increase the number of individuals with or at risk for prediabetes enrolled in DPPs
- Increase referrals to DPP programs
- Increase the number of accredited or recognized Diabetes Self-Management Education (DSME) programs (designed to be taught by licensed health professionals)
- Increase the number of Diabetes-Self-Management Support (DSMS) Services such as Stanford programs or the Diabetes Education and Empowerment Program (DEEP (designed to be taught by a non-licensed professional)
- Increase the number of participants in accredited/recognized DSME programs

- Increase the number of participants in licensed DSME programs (e.g., Stanford, DEEP)
- Increase referrals to DSME programs

Strategies

Funds/activities in the 809 cost center are to support evidenced-based strategies, specifically:

- Diabetes Prevention Programs (DPP) with an emphasis on achieving the Centers for Disease Control and Prevention (CDC) Recognition
- Comprehensive Diabetes Self-Management Education (DSME) programs with an emphasis on achieving American Association of Diabetes Educators' (AADE) accreditation, the American Diabetes Association (ADA) Recognition
- Stanford Diabetes Self-Management Programs (DSMP)

Interventions/Activities

Required activities vary by funding levels (Basic, Enhanced and Comprehensive.)* Each level has associated activities designated as Required (R), Strongly Suggested (SS), or Suggested (S). See the **Crosswalk**.

All funding levels are required to attend trainings and meetings/conference calls associated with their appropriate scope of work. Please note that some training costs will be the responsibility of the LHD. Whenever possible, trainings/meetings will be provided by webinar or phone, but some may require travel.

**LHDs with funding levels at the higher or lower ends of the range are encouraged to choose their activities accordingly.*

Staffing

Staff with various licensing, training, and skill sets can be used to complete this work; however, *a licensed health professional – preferably a licensed diabetes educator - is needed for the provision of Comprehensive DSME*. Staffing/programming must align with the National Standards for Diabetes Self-Management Education and Support (<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2797385/>) as well as KRS 309.325 to 309.339 – Diabetes Educator Licensure (www.bde.ky.gov). Standard #5, of the National Standards for DSME indicates:

*One or more instructors will provide DSME and, when applicable, DSMS. At least one of the instructors responsible for designing and planning DSME and DSMS will be a registered nurse, registered dietitian, or pharmacist with training and experience pertinent to DSME, or another professional with certification in diabetes care and education, such as a CDE or BC-ADM [or licensed diabetes educator (LDE/MLDE)]. Other health workers can contribute to DSME and provide DSMS with appropriate training in diabetes and with supervision and support... Individuals who serve as lay health and community workers and peer counselors or educators may contribute to the provision of DSME instruction and provide DSMS if they have received training in diabetes management, the teaching of self-management skills, group facilitation, and emotional support. **For these individuals, a system must be in place that ensures supervision of the services they provide by a diabetes educator or other health care professional and professional back-up to address clinical problems or questions beyond their training.***

Other evidence-based models such as Stanford Diabetes Self-Management Program, Diabetes Education and Empowerment Program (DEEP), the Diabetes Prevention Program (DPP), etc. can be provided by a trained facilitator or coach.

Planning and Reporting

Diabetes –CATALYST, (<http://diabetes-catalyst.cquest.us/Home/default.asp>), the web-based planning and reporting system, is to be used for all levels to submit plans for the 809 cost center as follows:

- Basic – required interventions for this level will be prepopulated into the CATALYST workplan. LHDs will need to open this draft workplan and personalize it for their area.
- Enhanced – LHDs at this level are required to open the draft CATALYST workplan and personalize it as above, and then add required activities for the Enhanced level
- Comprehensive - LHDs at this level are required to open the draft CATALYST workplan and personalize it as above, and then add required activities for the Comprehensive level

Plans will be due via the CATALYST system on or before June 30, 2016.

Diabetes-CATALYST is also to be used for reporting activities. Exceptions to this are the CARE Collaborative which is to be reported in the CARE Collaborative Online Data Collection Tool and services with the KDPCP umbrella DSME Accreditation Program which are to be reported in DiaWeb.

- All reporting must be completed in CATALYST by July 15, 2017.

Contact Person

Theresa Renn, RN, CDE, MLDE

(502) 564-7996 ext. 4442

theresa.renn@ky.gov

**Kentucky Diabetes Prevention and Control Program
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FY 17 Crosswalk

S = Suggested, SS= Strongly Suggested, R = Required

Expectations for Funding Levels and Crosswalk with CATALYST Framework

CATALYST Goal	CATALYST Activity Type	Intervention	Basic ≤\$20,000	Enhanced >\$20,000-70,000	Comprehensive >\$70,000
E-1 Monitor D/M Health Status to identify health problems	+Community Needs or DM Resources Assessment	Update the KDPCP Community Diabetes Resources Assessment	R	R	R
	+Edu-Share Findings w/Stakeholders	Share findings from assessment with stakeholders (e.g., board of health)	R	R	R
E-3 Inform, Educate & Empower people about diabetes prevention health issues	+Edu-Presentation to Public Group	Prediabetes awareness presentation to public group (e.g., lions club, etc.)	R (at least 1 activity)	R (at least 1 activity)	R (at least 1 activity)
	Media Generic	Deliver prediabetes information (radio, newspaper) to large audiences	R (at least 1 activity)	R (at least 1 activity)	R (at least 1 activity)
	Edu-National DPP (used when LHD is providing the program alone or with partner)	Establish/Provide/Maintain CDC Recognized Diabetes Prevention Program (DPP)	S	R (if no other provider, if not doing DSME)	R (if no other provider)
E-3 Inform, Educate & Empower people about diabetes control health issues	+Edu-Comp DSME	Accredited comprehensive DSME delivered at least 1/Co.	S	R (if no other provider, if not doing DPP)	R (if no other provider)
	+Edu-Non Comp. DSME	Provide brief/basic non-comprehensive diabetes education (e.g. <i>Diabetes or Nutrition Basics</i>)	R (unless offering DSME)	R (unless offering DSME)	S (DSME Required)
	+Edu-Presentation to Public Group	Diabetes awareness presentation to public group (e.g., lions club, etc.)	R	R	R
	-Edu-Support Gr. w/ Edu.-Edu-Stanford D/M or CD Self-management Program	Provide diabetes self-management support (DSMS) and other evidence-based non-comprehensive education	S	SS	SS

CATALYST Goal	CATALYST Activity Type	Intervention	Basic (≤\$20,000)	Enhanced (>\$20,000-70,000)	Comprehensive (>\$70,000)
E-4 Mobilize Partnerships/Resources to identify and solve health problems	+Meeting-Attend/Facilitate D/M Coalition +Est. New Diabetes Coalition/Council	Establish or maintain a local diabetes coalition/community council - and link to the state coalition, the KY Diabetes Network (KDN)	S	SS	R
	-Meeting- Kentucky Diabetes Network (KDN)	Participate in the state coalition (KDN)	S	SS	R (assist with leadership)
	-Improve Environment (Worksite, Community Physical, Social, Econ.)	Promote efforts led by other partners/programs to create environments that support physical activity and/or healthy nutrition ("Step it Up," Farmers markets)	S	S	S
	Meeting/other Coalition	Establish/maintain a local, regional, state, or national diabetes professional coalition (KADE, GLADE, TRADE, PFK, Healthy Communities)	S	SS	SS
E-5 Influence/Develop public policies & plans that support individual & statewide diabetes efforts	+Edu-State/Local Policy Makers	Develop/Promote policies and payment mechanisms for DSME and DPP	S	S	R

CATALYST Goal	CATALYST Activity Type	Intervention	Basic (≤\$20,000)	Enhanced (>\$20,000-70,000)	Comprehensive (>\$70,000)
E-7 Link people to needed personal diabetes Health Services/Education/ Access	+Distribute/Update Info-D/M Resource Dir.	Enter/Update local diabetes resources and share with the community	R	R	R
	+Promote DSME/DPP Referrals/Referral Mechanisms	Facilitate referral/linkage to DSME and DPP from other LHD programs/activities (Humana Vitality screenings, family planning, etc.)	R	R	R
	+Build Relationships w/Local Service Providers	Establish referral mechanisms for DSME/DPP from providers, health plans (prescription pads, EHR prompts, e-referrals, marketing/awareness visits to providers, etc.)	SS	R	R
	+Promote DSME/DPP Reimbursement Models/Payment Mechanisms	Collaborate with state partners to develop/promote reimbursement models, policies and payment mechanisms for DSME and DPP	S	S	R
	+Establish New DPP/DSME Program	Build relationships with local agencies interested/potentially interested in offering DPP and/or DSME and provide support/link to resources	S	SS	R
	+Provide TA to Increase Accredited DSME/DPPs	Provide leadership/assistance to others working toward DSME Accreditation or CDC Recognized DPP	S	SS	R
	+Build Relationships w/Employers/Worksites +Promote Benefit Designs w/ DSME/DPP to Employers	DPP or DSME awareness efforts provided to 1 or more worksites (industry, schools, etc.) in the service region	S	S	SE

CATALYST Goal	CATALYST Activity Type	Intervention	Basic (≤\$20,000)	Enhanced (>\$20,000-70,000)	Comprehensive (>\$70,000)
E-8 Assure competent public & personal diabetes health care workforce	+Attend CATALYST Plan/Report Training	Attend initial CATALYST training and then updates as needed	R	R	R
	+Meeting – KDPCP (Conf. Calls, Webinars, etc.)	Attend scheduled 809 calls (make other arrangements if not able)	R	R	R
	+Attend Training/Conf./CEU	Attend 1 or more: State Diabetes Symposium, Corbin symposium, TRADE, KADE, DECA or GLADE programs, or other CEU (and share)	R (for staff providing DSME)	R (for staff providing DSME)	R (for staff providing DSME)
	Attend National Conference	Attend AADE annual meeting or other applicable national meeting (AND, ADA)	S	SS	SS
	+Attend Training to Provide DPP	Complete DPP coaches training	R (if doing DPP)	R (if doing DPP)	R (if doing DPP)
	+ Attend Training to Provide DSME	Complete KDPCP training to provide DSME	R (if doing DSME)	R (if doing DSME)	R (if doing DSME)
	+Develop/Recruit New CDE/LDE	Pursue, and encourage others to pursue, CDE and/or licensure as a diabetes educator (LDE) if applicable	S	SS	SS
	+Edu-Presentation to a Prof. Group Edu-Assist/w Training/Conf/CEU +Organize Training/Conf./CEU	Provide/assist with professional education trainings provided in the service region or state.	S	S	SS
Develop/Update Materials/Tools	Participate on a KDPCP workgroup to address identified program initiatives for KY (symposium committee, DPP steering committee, etc.)	S	S	SS	

CATALYST Goal	CATALYST Activity Type	Intervention	Basic (≤\$20,000)	Enhanced (>\$20,000-70,000)	Comprehensive (>\$70,000)
E-9 Evaluate effectiveness, accessibility, & quality of diabetes care & prevention services	+Complete Readiness Assessment for Umbrella KDPH AADE Accreditation	For those doing DSME, consider application to be a part of the umbrella KDPH AADE accreditation program	SS (if doing DSME)	SS (if doing DSME)	SS (if doing DSME)
	+Submit Application for Nat. DPP Recognition	Those delivering DPP services need to apply for Recognition status with CDC	R (if doing DPP)	R (if doing DPP)	R (if doing DPP)
	+Report Annual # Unduplicated People in LHD Comp. DSME Classes	Report in CATALYST (unless already reported in DiaWeb as part of the DEAP) the # of unduplicated people attending at least 1 LHD comprehensive DSME class during the year.	R (if doing DSME)	R (if doing DSME)	R (if doing DSME)
	+Report Annual # Unduplicated People in LHD DPP Classes	Report in CATALYST the # of unduplicated people in DPP cohorts provided/completed during the year by the LHD.	R (if doing DPP)	R (if doing DPP)	R (if doing DPP)
Increase A1C, blood pressure, & cholesterol (ABC) testing/control among individuals with diabetes	+Media generic	Deliver diabetes cardiovascular health ABC's awareness information to large audiences (radio, newspaper, billboard, etc.)	R (at least 1 activity)	R (at least 1 activity)	R (at least 1 activity)
	+Edu-Presentation to Public Group, Media Activities, Distribute Materials, Display	Provide diabetes and cardiovascular health ABC's awareness campaign (ideally at least 3 different activities).	R (at least 1 activity)	R (at least 1 activity)	R (at least 1 activity)

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FY 17 Diabetes Plan Guide

The following examples of SMART Activity Descriptions can be copied, pasted and adapted as applicable to develop your workplan.

KEY: Shaded areas are preloaded as basic plan in CATALYST + Indicates a priority program activity S=Suggested, SS=Strongly Suggested, R=Required

Goal	Activity	SMART Activity Description	Basic Funding	Enhanced Funding	Comprehensive Funding
E- 1 Monitor Diabetes Health Status	+Community Needs or D/M Resources Assessment	By March 31, 2017, complete 2 Community Diabetes Resource Assessment components: 1) Update the annual Community Diabetes Resource Assessment 2016-17 for our service region, 2) Complete KDPCP requested summary information from the assessment in Survey Monkey.	R	R	R
	+Edu-Share Findings w/ Stakeholders	By _____ (month/year), share the findings from the Community Diabetes Resource Assessment with at least 2 service region stakeholders including _____ (list entities you plan to target, i.e. diabetes coalition, board of health, organizations with diabetes resources, community health coalition, etc.) in _____ county(s).	R	R	R
	Distrib. Materials/Tools	By _____ (month/year) diabetes staff will develop a cover letter and distribute the most recent KDPCP Diabetes Fact Sheet to at least ___ (number) stakeholders that might include _____ (list stakeholders such as ADD office, county judges, hospitals, extension services, health coalitions, newspaper, radio station, etc.) in _____ county(s).	S	SS	SS
E- 3 Inform/Edu/Emp-D/M Prevention	+Edu-Presentation to Public Group	By _____ (month/year) provide at least 1 prediabetes awareness presentation to _____ (list a public group you plan to target, i.e. Lions Club, Rotary Club, faith group, home makers, senior citizens, etc.) in _____ county(s).	R At least one activity	R At least one activity	R At least one activity

	Media-Generic	By _____ (month/year) arrange for the delivery of prediabetes/diabetes awareness information to at least 1 large audience utilizing _____ (list the media outlet(s) you plan to utilize, i.e. radio, TV, newspaper, newsletter, payroll stuffer, billboard, church bulleting insert, movie theater ad, bus, bus shelter or park bench, website or social media, marquee, wallboard or banner, etc.)in _____ county(s).	R At least one activity	R At least one activity	R At least one activity
	+Edu-National DPP	By ____ (month/year), diabetes education staff will have initiated at least ____ (#) series of DPP classes in _____ county(s). Data will be submitted to CDC as required to achieve full recognition status.	S	R If no other provider	R If no other provider
	Distrib. Materials/Tools	By _____ (month/year) information on preventing diabetes will be distributed at health fairs, festivals, flu clinics, Unemployment Office, churches, restaurants, clinics, beauty salons, nail parlors and other businesses in _____ county(s).	S	S	S
	Media-Newsletter/Newspaper Article/Ad/Release	By _____ (month/year), submit an article to _____ (enter #) local newspaper(s) in regards to prediabetes awareness in _____ county(s). OR By _____ (month/year), a DPP success story will be shared with _____ (enter #) local newspaper(s) to promote the importance and awareness of DPP being offered in the community.	S	S	S
	Media-Radio Program/PSA	By ____ (month/year), staff will speak on at least ____ radio programs re: prediabetes/prevention of type 2 diabetes.	S	S	S
	Media-TV Program/PSA	Provide a television program for local television, on diabetes prevention, to be aired during the month of ____ (month/year) and as filler for the television station at other times during the year.	S	S	S
	Meeting-Info, Planning, TA, Etc.	By ____ (month/year), diabetes education staff will have attended at least ____ planning meeting for implementation of DPP in the community.	S	S	S

	Display-Health Fair/Other Public Event	By _____ (month/year) set up a booth at our local Community Days. We will provide information on DPP program including information will be given about the program, classes and prevention.	S	S	S
	Edu-Healthy Lifestyle Support/Microclinic	By ____ (month/ year), provide healthy nutrition education talks to _____(enter #) public groups. Topics include portion control for diabetes prevention and weight control. Also sodium education for hypertension control. OR By ____ (month/year), provide at least ____ (enter #) class(es) in the community on Healthy Eating and Making Better Choices.	S	S	S
	Edu-Power to Prevent Type 2 Diabetes	By ____ (month/year), present at least ____ (enter #) Power of Prevention classes from which to refer to the local DPP classes.	S	S	S
	Physical Activity Event Program	By _____ (month/year) collaborate with community partner organizations in _____ county(s) to provide _____(example: Walk with Ease Arthritis Foundation Program, walking competition event, etc.) which increases physical activity in the community and promotes prevention and control of type 2 diabetes.	S	S	S
E- 3 Inform/Edu/Empower- D/M	+Edu-Non-Comp. DSME	By ____ (month/year), diabetes education staff will offer ____ (number of classes) non-comprehensive education using the Diabetes Basics & Nutrition Basics curriculum in _____ County(s).	<i>R</i> <i>Unless offering DSME</i>	<i>R</i> <i>Unless offering DSME</i>	<i>S</i> <i>DSME required</i>
	+Edu-Presentation to Public Group	By____ (month/year) provide at least 1 diabetes awareness presentation to _____ (list a public group you plan to target, i.e. Lions Club, Rotary club, faith group, home makers, senior citizen, etc.) in _____ county(s).	R	R	R
	Display-Health Fair/Other Public Event	By the end of ____ (month/year) staff will provide diabetes information booths and displays at____ (enter #) health fairs in _____county(s).	S	S	S
	Distrib. Materials/Tools	By ____ (month/year), staff will promote flu/pneumonia vaccinations by distributing tools/materials such as bags, posters	S	S	S

		and brochures to _____ (enter #) of community partners.			
	+Edu-Comp. DSME	<p>By the end of ____ (month/year), at least ___ series of comprehensive DSME will be offered. Class series are planned as follows: The series consists of ____ hour x ____ (classes). OR Contract to provide ____ series of comprehensive DSME classes by June 2017. Each series will consist of ____ hours x ____ number classes and will be offered in _____county(s). OR By _____ (month/Year), provide ____ series of comprehensive DSME classes as a branch of the Healthy Living with Diabetes KDPH AADE Accredited Program. Each series will consist of ___ classes that are ____ hours each with an average attendance of ____ people per class. Data will be entered in DiaWEB.</p>	S	<i>R</i> <i>If no other provider in the county offers DSME</i>	<i>R</i> <i>If no other provider in the county offers DSME</i>
	Edu-Support Gr. w/Edu	<p>By the end of _____(month/year), diabetes education staff will offer and lead ____ (number) diabetes support groups with education in district/county with various education topics such as foot care, eye care and cooking for the holidays. OR By ____ (month/year) provide _____ (number) diabetes children focused support groups within _____county(s).</p>	S	SS	SS
	Media-Newsletter Publication	By the end of ____ (month/year), diabetes education staff will have developed and distributed ____ (number during the year) Diabetes Newsletter issues to approximately _____ (enter #) DSME past & present attendees.	S	S	S
	Media-Newsletter/Newspaper Article/Ad/Release	By the end of ____ (month/year), ____ (number) monthly articles (primarily NDEP) will be submitted to local newspapers in _____ county(s). Staff will check newspapers monthly and audience number will be modified if printed.	S	S	S

E- 4 Mobilize Partnerships/Resources	+Est. New Diabetes Coalition/Council	By ____ (month/year), establish ____ (#) new diabetes coalition(s) in _____ county(s).	S If not already a coalition	SS If not already a coalition	R If not already a coalition
	+Meeting-Attend/Facilitate D/M Coalition/Council	By the end of ____ (month/year), staff will facilitate and/or participate in ____ (enter #) meetings with ____ (name of the diabetes coalition(s)).	S	SS	R
	+Meeting-Kentucky Diabetes Network (KDN)	By ____ (month/year), staff will attend at least ____ (#) Kentucky Diabetes Network meetings and participate in workgroup sessions accordingly as well as participate in leadership positions as needed. (HDs with local diabetes coalitions are encouraged to have a representative from their local coalition at KDN meetings also.)	S	SS	R Assist with leadership
	Apply for Grant/Generate Funding	By ____ (month/year), apply for at least ____ (#) grant(s) to help support our local diabetes coalition and/or local diabetes prevention and control program efforts.	S	S	S
	Meetings/Other Coalition	By end of ____ (month/year) designated staff will participate in ____ (#) meetings of an AADE Local Networking Group (LNG) and Coordinating Body (CB) activities or group of local diabetes professionals like LNG groups. LNGs for Kentucky professionals are TRADE, KADE, GLADE, DECA OR By ____ (month/year) staff will participate in ____ meetings of the regularly scheduled community health partnership meetings, including annual and workgroup meetings.	S	SS	SS
	Improve Physical Environment	By ____ (month/year) work with local partners to establish ____ (#) local farmers market(s) in _____ (name of town or community). OR By ____ (month/year) support <i>Step it up Kentucky</i> and the work of the Healthy Communities Coalition with local government to adopt ____ (#) pedestrian plan(s) for ____ (name of town(s)).	S	S	S

E- 5 Influence/Develop Policies & Plans	+Edu-State/Local Policy Makers	By end of ____ (month/year), ____ (#) of workshops will be held to promote healthy workplace and policy change related to DSME/DPP with ____ (#) businesses in ____ county(s). OR By ____ (month/year) develop and promote policies and payment mechanisms for DSME/ DPP in ____ county(s).	S	S	R
	Develop Strategic Plan	By ____ (month/year), meet with our local diabetes council/ coalition to develop an annual strategic diabetes community plan.	S	S	SS
	Public Policy Forum-Attend	By the end of ____ (month), staff representing ____ county(s)/ district will attend Diabetes Day at the Capitol to educate legislators on the medical needs of Kentuckians with diabetes.	S	S	S
E- 7 Link to Health Serv/Edu/Access	+Distrib./Update Info-D/M Resource Dir.	By ____ (month/year), complete 3 Diabetes Resource Directory Components: 1) enter/update Diabetes Resources Assessment findings in the KY Diabetes Resource Directory (https://prd.chfs.ky.gov/KYDiabetesResources/); 2) utilize the Diabetes Resource Directory to create/print a listing of local diabetes resources for distribution; and 3) share the printed listing and/or how to access the website with diabetes providers, medical staff, and others as appropriate in our service regions.	R	R	R
	+Promote DSME/DPP Referrals/Referral Mechanisms	By ____ (month/year), have referral mechanisms in place and/or facilitate referral/linkages for DPP/DSME from other LHD programs/activities such as ____ (list things such as Humana Vitality screenings, Family Planning, health fairs, community presentations/events, etc.)	R	R	R
		as well deliver, DSME and DPP prescription pads and referral forms that can be faxed to ____ (Health Department) will be delivered to at least ____ (#) provider offices. OR as well as collaborate with state KDPCP staff to develop/promote reimbursement model(s), policies and payment mechanisms for DSME/DPP. OR as well as communicate, either by mail, phone or in person to	S	S	R

		upper level management with ____ (#) local Federally Qualified Health Center (FQHC) providers to streamline the referral process. Will also send tools/updates about diabetes management. Class lists will be sent, and DSME classes will be set at a location near the FQHC address to accommodate referrals from each site.			
	+Build Relationships w/ Employers/Worksites	By the end of ____ (month/year), staff will make an appointment and visit at least ____ (#) of the larger employers in the community to establish a relationship and promote prediabetes/ diabetes awareness. OR By ____ (month/year) will work with the ____ (County Name) Board of Education to offer Power of Prevention presentation for school staff after Human Vitality screenings particularly targeting individuals with blood glucose values in the prediabetes range. OR By ____ (month/year), staff will make an appointment to visit ____ (#) large employer(s) in ____ county(s) to establish a relationship and promote prediabetes and diabetes awareness and education.	S	S	SS
	Other (Detail in Text Box)	By ____ (month/year), staff will refer clients who are seen in clinic and who attend DSME Classes to Stanford Chronic Disease Self-Management Program in ____ county(s).	S	S	S
	+Build Relationships w/ Loc. Service Providers	By ____ (month/year), market DSME programs to ____ (#) local physicians through office visits utilizing class flyers, post it notes and ABC awareness business cards. OR By ____ (month/year), staff will visit at least ____ providers and pharmacies in ____ county(s) promoting the DSME/DPP classes and educating them of our diabetes services. Will distribute office posters, flyers, rack cards, prescription pads, pens and resource directory info cards.	SS	R	R

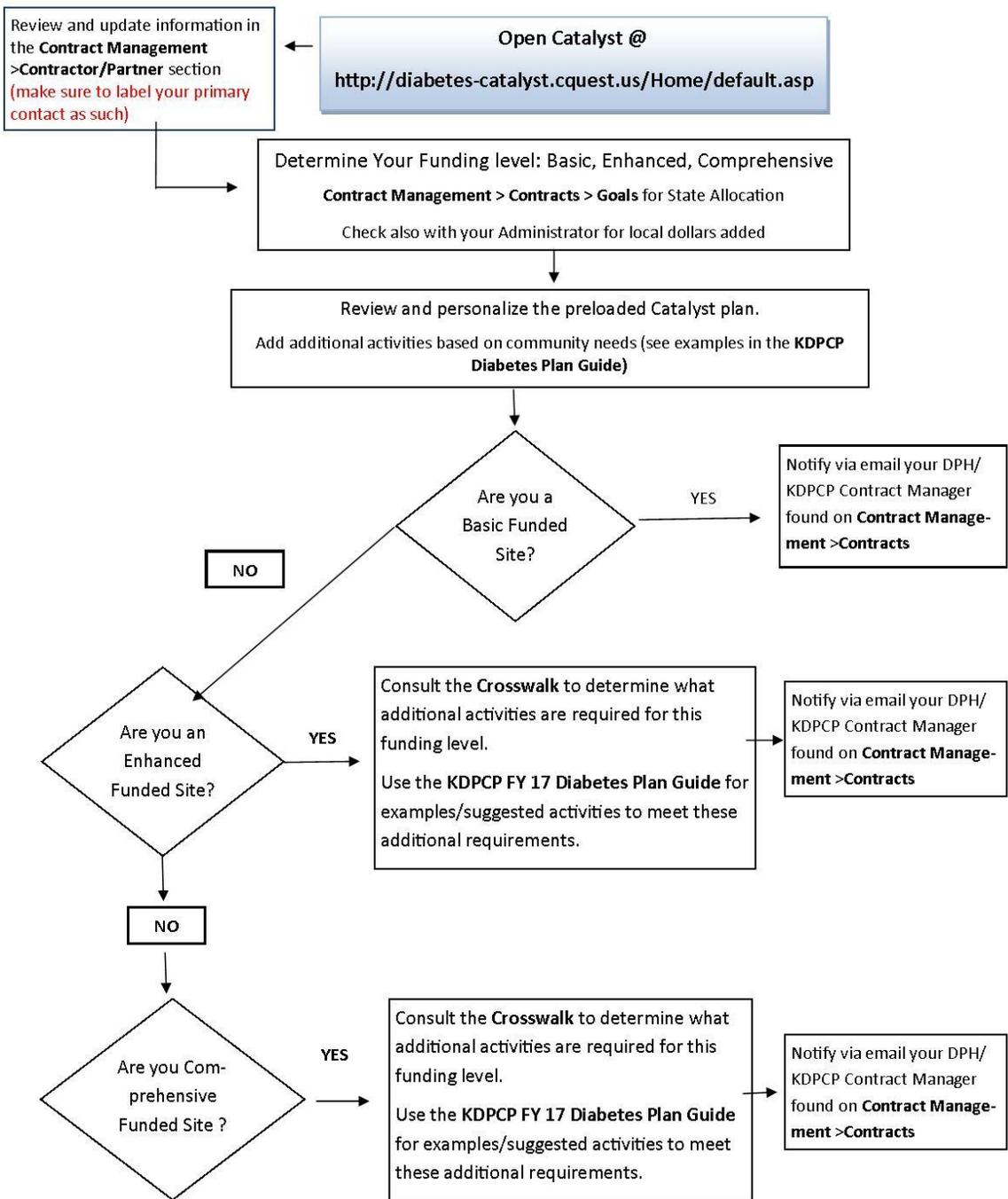
	+Est. New DPP/DSME/Program	By _____(month/year) build relationships with ____ (number) of local FQHC's, hospitals and ____ (number) pharmacies interested in developing a Diabetes Prevention Program. Provide support and link resources at state level for development of a new program in _____county(s).	S	R If not offering DPP and/or DSME	R Or collaborate to enhance existing services
	Develop/Update Material/Tools	By ____ (month/year), staff will prepare community calendars ____ (#) times during the year to take to health care provider offices in the community. The calendars will include all the known diabetes resources and classes offered in the district as submitted to health department by providing organizations.	S	S	SS
	+Provide TA to Increase Accredited DSME/DPPs	By the end of ____ (month/year), staff will participate with KDPCP to provide technical assistance for programs working toward recognition for ____ (type of accreditation: DPP and/or AADE) accreditation.	S	SS	R Collaborate to enhance existing services
E- 8 Assure Competent D/M Workforce	+Attend CATALYST Plan/Report Training	Staff will attend any CATALYST updates if offered or new user training as needed by June 2017.	R	R	R
	+Meeting-KDPCP (Conf. Call, Webinars, etc.)	By June 30, 2017 staff will participate in at least ____ (enter #) KDPCP conference calls, webinars or face to face meetings to keep up to date with diabetes information, the diabetes program and other diabetes-related activities in state.	R	R	R
	+Attend Training/Conf./CEU	By the end of ____ (month) staff will attend at least ____ (#) CEU offerings to acquire the required 15 CEUs for AADE accreditation. OR By ____ (month/year) ____ (number) of staff will attend the annual diabetes symposium to help stay up to date with the latest diabetes information and to help acquire the required 15 CEUs to maintain diabetes educator licensing or LDE.	R For staff providing DSME	R For staff providing DSME	R For staff providing DSME
	Attend National Conference	By_____(month/year), staff will attend the AADE Annual meeting.	S	SS	SS

	+Attend Training to Provide DPP	By the end of ____ (month/year), new staff will attend the Lifestyle Coach Training/DPP. OR At least ____ (#) staff member(s) will be trained in DPP by the end of the fiscal year and participate in ____ (#) DPP conference calls.	R If doing DPP	R If doing DPP	R If doing DPP
	+Attend Training to Provide DSME	By the end of ____ (month), new staff will complete the 3 components of the KDPCP DSME training.	R If doing DPP	R If doing DPP	R If doing DPP
	+Develop/Recruit New CDE/LDE	By the end of ____ (month/year), eligible staff will complete application process for LDE apprentice process and work on hours for LDE/CDE status.	S	SS	SS
	+Edu-Assist w/ Training/Conf./CEU	By the end of ____ (month/year), staff will participate with KDPCP _____ (type of) trainings as invited. OR By ____ (month/year), ____ (#) staff member(s) will participate on the planning committee to provide the Annual Statewide Diabetes Symposium.	S	S	SS
	Mentoring	By ____ (month/year), staff will provide TA assistance to ____ (#) other LHDs new to DSME.	S	S	SS
	+Edu-Organize Training/Conf./CEU	By the end of ____ (month/year), staff will organize, coordinate, and present one CEU program for nurses who are caring for individuals with diabetes.	S	S	SS
	Edu-Presentation to a Prof. Group	By ____ (month/year) provide a diabetes presentation to the _____ (staff at long term care facility, school, fire department, police station, hospital, etc.)	S	S	SS
E- 9 Evaluate Effectiveness/Quality	+Complete Readiness Assessment for Umbrella KDPH AADE Accreditation	By the end of ____ (month/year), _____ (Health Department) will work with KDPCP state staff to complete a readiness assessment for the Healthy Living with Diabetes KDPH Umbrella AADE Accredited DSME program..	SS If doing DSME	SS If doing DSME	SS If doing DSME
	+Submit Application for National DPP Recognition	By the end of ____ (month/year), _____ (Health Department) with trained DPP lifestyle coaches will apply for CDC recognition.	R If doing DPP	R If doing DPP	R If doing DPP

	+Report Annual # of Unduplicated People in LHD Comp. DSME classes	By the end of _____(month/year) report in CATALYST the number of unduplicated people in LHD comprehensive DSME classes provided/completed during year in _____county(s).	R If doing DSME	R If doing DSME	R If doing DSME
	+Report Annual # of Unduplicated People in LHD DPP classes	By the end of _____(month/year) report in CATALYST the number of unduplicated people in DPP cohorts provided/completed during year in _____ county(s).	R If doing DPP	R If doing DPP	R If doing DPP
	Meeting-Info, Planning, TA, Etc.	By the end of ____ (month/year), staff will attend at least ____ (number) staff meetings to discuss, review charts, evaluate outcomes, and plan diabetes activities for the diabetes program in the district. These will be entered as District-wide activities. OR By the end of ____ (month/year), staff will meet with supervisor to determine local 809 program needs, what is working, what needs improvement and how to make it happen, CQI projects. Discuss outcomes and share info for stakeholders in _____county(s).	S	S	SS
Increase ABC Testing/Control Ideal to have at least 3 different informational	+Media- Generic	By _____(month/year) arrange for the delivery of diabetes cardiovascular health ABC's awareness information to at least 1 large audience utilizing _____ (list the media outlet you plan to utilize, i.e. radio, TV, newspaper, newsletter, payroll stuffer, billboard, church bulleting insert, movie theater ad: bus, bus shelter or park bench: website or social media, marquee, wallboard or banner, etc.) in _____county(s).	R At least one activity	R At least one activity	R At least one activity
	+Edu-Presentation to Public Group	By ____ (month/year), staff will promote the ABC message by ____ (#) presentation(s) to a public group as well as promoting the message thru tools – fans, pens, jar openers, water bottles.	R At least one activity		
	Media- Newsletter/Newspaper Article/Ad/Release	By (monthly/year), provide an NDEP article on the ABCs of diabetes to ____ (enter #) local newspapers (s) with total circulating audience of ____ (number).			

	Media-Radio Program/PSA	Provide interview for the morning show on _____ local station(s) by _____ (month/year) for promotion of diabetes awareness month and ABC's of diabetes control in _____ county(s).	
	Media-Web Based Materials/Message	By _____ (month/year), provide NDEP article to _____ (enter#) local health department web page.	

Kentucky Diabetes Prevention and Control Program
Cost Center 809 (Diabetes)
FY 17 CATALYST Flow Chart



Revised 5/17/16

**Kentucky Diabetes Prevention and Control Program
Cost Center 809 (Diabetes)**

FY 17 Acronyms and Definitions

809 Cost Center	Diabetes cost center for local health departments
AAA	Area Agency on Aging – promotes the well-being of older individuals by providing services and programs designed to help them live independently in their homes and communities. http://chfs.ky.gov/dail/areaagenciesonaging.htm
AADE	American Association of Diabetes Educators – a multi-disciplinary professional membership organization dedicated to improving diabetes care through education. http://www.diabeteseducator.org/
ABC Awareness Campaign	Awareness materials that address A: A1c control, B: Blood Pressure Control, C: Cholesterol Control
AHEC	Area Health Education Center: http://soahec.org/
ADA	American Diabetes Association: Mission is to prevent and cure diabetes and improve the lives of all people affected by diabetes. http://www.diabetes.org/
BRFSS	Behavioral Risk Factor Surveillance System – is the world’s largest, on-going telephone health survey system. http://www.cdc.gov/brfss/
BC-ADM	Board Certified Advanced Diabetes Manager
CARE/Care Collaborative	The Cardiovascular, Assessment, Risk Reduction and Education (CARE) collaborative, promoted by the KY Heart Disease and Stroke Prevention Task Force, is a free blood pressure awareness program for adults and is part of the <i>Million Hearts</i> Initiative.
CATALYST	Data system for recording diabetes 809/841 plans and activities
CDC	Center for Disease Control: http://www.cdc.gov/diabetes/home/index.html
CDE	Certified Diabetes Educator – (national certification via a specific process) a health professional who possesses comprehensive knowledge of, and experience in, diabetes management, prediabetes, and diabetes prevention and educates/supports people affected by diabetes to understand and manage the condition. http://www.ncbde.org/
CDSMP	Stanford Chronic Disease Self-Management Program (lay leader model) http://patienteducation.stanford.edu/programs/cdsmp.html
Clinical-Community Linkages	Collaborations between health care practitioners in clinical settings and programs/services in communities
CMS	Center for Medicare and Medicaid Services: http://www.cms.gov/
Cohorts	A group of individuals with a common statistical characteristic. For example, “a cohort of women between 25 and 30 years of age.” This term is often utilized for a specific group of DPP/NDPP class participants.
Cooperative Extension	http://extension.ca.uky.edu/
DEAP	Diabetes Education Accreditation Program (from the American Association of Diabetes Educators). This is a National accreditation that some LHDs have achieved.
DECA	Diabetes Educators of the Cincinnati Area – a local networking group of the American Association of Diabetes Educators

DEEP	Diabetes Education Empowerment Program: This program utilizes trained community health workers and is aimed at reducing diabetes mortality and morbidity and related complications. The Patient Education Program is implemented in 8-10 weekly sessions via a set curriculum. http://www.hvusa.org/services/in-allen-county-in/104-diabetes-education-empowerment-program-deep .
Diabetes Alert Day	Alert Day (Fourth Tuesday in March) is a call to take the Type 2 diabetes risk test http://www.diabetes.org/are-you-at-risk/alert-day/?loc=superfooter
Diabetes Basics (booklet)	Educational tool available in the pamphlet library and at: http://chfs.ky.gov/dph/info/dpqi/cd/PatTools.htm
DiaWEB	Data Management System for DSME activities/DEAP programs.
DPP/NDPP	Diabetes Prevention Program/National Diabetes Prevention Program: an evidence-based lifestyle change program for preventing type 2 diabetes. http://www.cdc.gov/diabetes/prevention/index.htm
DPP Provider Toolkits	Collection of materials/tools about DPP that are of interest to health care providers www.haltidiabetes.org
DSME	Diabetes Self-Management Education – Diabetes education helps individuals with diabetes learn how to manage their disease and be as healthy as possible. It focuses on seven self-care behaviors: Being Active, Healthy Eating, taking Medications, Healthy Coping, Reducing Risk, Problem Solving, and Monitoring. <i>Comprehensive – including 6-8 hours of instruction, taught by health professional (RN, RD, LDE) using a curriculum including core topics listed in Standard 6 of the NSDSMES. (KDPCP’s curriculum meets this standard.)</i> <i>Non-Comprehensive – Covering only certain topics/support services</i>
DSMS	Diabetes Self-Management Support (DSMS) – Activities that assist the person with prediabetes or diabetes in implementing and sustaining the behaviors needed to manage his or her condition on an ongoing basis beyond or outside of formal self-management training.
DTTAC	Diabetes Training and Technical Assistance Center: assists organizations to develop/grow effective diabetes prevention and control programs (customized trainings, a variety of tools and products, and individualized technical assistance). http://www.dttac.org/
EPHS	Essential Public Health Services (TRAIN Module: Public Health Orientation #1008492)
GLADE	Greater Louisville Association of Diabetes Educators – a local networking group of the American Association of Diabetes Educators (AADE).
Healthy Living with Diabetes - KY Dept. for Public Health (HLWD)	Kentucky public health’s accredited DSME program. LHDs that meet readiness requirements for being a branch of the HLWD program are considered for acceptance into the program and trained.
KADE	Kentucky Association of Diabetes Educators – a local networking group of the American Association of Diabetes Educators (AADE). AADE is the leading organization for diabetes educators, professionals who are dedicated to supporting successful self-management as a key outcome in the care of people with and at risk for diabetes: http://www.kadenet.org
KDN	Kentucky Diabetes Network: Statewide Diabetes Coalition http://www.kydiabetes.net/
KDPCP	Kentucky Diabetes Prevention and Control Program: www.chfs.ky.gov/diabetes
KEHP	Kentucky Employee Health Plan

LDE	Licensed Diabetes Educator www.bde.ky.gov
LHD	Local health department
LNG	Local Networking Group – groups of local diabetes educators affiliated with AADE National. See KADE, GLADE, TRADE, DECA
MLDE	Master Licensed Diabetes Educator – a licensed diabetes educator who is also a CDE or BC-ADM
MNT	Medical Nutritional Therapy
NCQA	National Committee for Quality Assurance: http://www.ncqa.org/Search.aspx?Search=diabetes
NDEP	National Diabetes Education Program: http://ndep.nih.gov/
NSDSMES	National Standards for Diabetes Self-Management Education and Support – designed to define quality DSME and assist diabetes educators in a variety of settings to provide evidence-based education: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2797385/
Nutrition Basics (booklet)	Educational tool available through the pamphlet library or at: http://chfs.ky.gov/dph/info/dpqj/cd/PatTools.htm
PHAB	Public Health Accreditation Board TRAIN Module: 1030975
Prediabetes	A blood sugar level higher than normal, but not high enough for a diagnosis of diabetes creating a higher risk for developing type 2 diabetes and other serious health problems, including heart disease, and stroke. Without intervention, 15% to 30% of people with prediabetes will develop type 2 diabetes within five years. (CDC)
PFK	Partnership for a Fit Kentucky
PWD	People With Diabetes
Q-Source	A Medicare Quality Improvement Organization/Network – (a group of health quality experts, clinicians, and consumers organized to improve the care delivered to people with Medicare), working with KY, IN, TN: http://atomalliance.org/
Resource Directory	Current listing of diabetes-related service providers in KY and surrounding counties (DSME classes, DPP classes, MNT, and more): https://prd.chfs.ky.gov/KYDiabetesResources/
Results	Indicators that demonstrate an event or events are complete within a LHD workplan. In CATALYST, results are entered by LHDs on three screens – one screen for outputs, one for key partners and one for evaluation.
Stanford DSMP	Stanford Diabetes Self-Management Program (lay leader model): http://patienteducation.stanford.edu/programs/diabeteseng.html .
Step it Up	Surgeon General’s call to action to promote walking and walkable communities. http://www.surgeongeneral.gov/library/calls/walking-and-walkable-communities/index.html
TA	Technical Assistance
TRADE	Tri-State Association of Diabetes Educators - a local networking group of the American Association of Diabetes Educators (AADE). AADE is the leading organization for diabetes educators, professionals who are dedicated to supporting successful self-management as a key outcome in the care of people with and at risk for diabetes
SMART	An acronym for well written goals which are: Specific, Measureable, Achievable, Relevant, and Time-bound.
Workplan	Documentation of what a LHD is planning to do during the fiscal year to utilize 809 funds. It is entered in CATALYST and incorporates SMART objectives and target audiences.

